

Pharmacy Benefit Managers: Poor Accountability and Transparency Harm Medicaid Patients and Independent Pharmacies

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September 2023



Real time reporting

September 14, 2022

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September 14, 2022
Representative Nancy Nathanson
Oregon Legislature
9500 NE Oregon St
Salem, OR 97331

Dear Representative Nathanson:
As requested in your request, we are providing information about leading practices related to hearing practices related to pharmacy benefit managers (PBMs). This letter identifies potential opportunities for legislative action related to Oregon PBMs.

States have implemented these practices in the Medicaid program or public employee health plans and are taking a variety of approaches to support PBM models. Each approach has different costs and benefits and there is no perfect solution.

Health equity concerns
Pharmacy classes have negatively impacted Oregon rural and frontier communities, as studies illustrate how pharmacy closures affect rural communities and disproportionately impact Black and Latino communities. Pharmacy access is a critical component of health care and any impact to providing health services for the people of Oregon. If PBMs are not directly positioned in their community to address gaps in care by collaborating with other health care providers, which may help address health disparities. For these reasons, areas should be considered to protect Oregon pharmacies.

Pharmacy protections
Pharmacy audits, negotiations, and appeals
PBMs require each pharmacy to identify unique circumstances and verify the patient received the correct medication and dosage. There is a risk PBMs could abuse the process to receive money from expenses/procedures for other activities even though that is not the intent. Some states have

implemented laws to ensure pharmacies are audited fairly and given processes for appeal. Oregon has some laws in place for pharmacy audit protections, though it is important to note current PBM regulatory structures do not apply to Medicaid managed care PBM relationships or where insurers act as their own PBM.

Despite these laws, pharmaceuticals have established predatory practices as occurring and noted the multiple process to understand and time-consuming. The Oregon Department of Consumer and Business Services can investigate complaints submitted by pharmacies against PBMs for some issues, including violation of MFC (consumer advocate) cost pricing requirements, predatory pharmacy audit practices, and violation of "true claims" laws. Examples: [MFC 310000](#) and [MFC 310000](#).

True pharmacy reimbursement
The number of pharmacy has been falling across the nation, and local, independent pharmacies have been closing the fastest, being priced to shut pharmacies to clear or addressing health resources and supporting positive health outcomes at the individual and population level. Low reimbursement rates are often cited as a major factor for pharmacy closures and some states have provisions for full reimbursement. Approaches from other states include reducing PBMs from reducing the amount reimbursed on a case-by-case basis or requiring the use of National Average Drug Acquisition Costs as a basis for market-based rates. Some states require PBMs to disclose the methodology for maximum allowable cost lists to provider pharmacies, and others have limited fees a PBM can levy on a pharmacy. Examples: [Oregon 310000](#) and [MFC 310000](#).

Figure 1. Many states have established policies for volume formulas for all or some drug classes in their cost managed care.



Increased transparency

Reporting and transparency requirements
Most states have implemented laws requiring PBMs to disclose contracting and cost information such as audit results, or payment and fee schedules from drug manufacturers and pharmacies. The Idaho Health Regulators and Health Plans to make informed decisions regarding whether PBMs are providing benefits and delivering good value. Examples: [Oregon 310000](#) and [MFC 310000](#).

Some states have passed laws requiring greater transparency for reporting for PBMs. Some states with uniform regulatory legislation for Medicaid require the same formulary for all managed care health plans, while others have chosen to allow uniform formulary for only certain classes of drugs. See the PFM for the Special model: [Oregon 310000](#) for more information on states that have already carved out pharmacy benefits from managed care, which would also produce a uniform formulary and coverage criteria for all Medicaid members. A shift to this structure should include considerations for plans in implementation that will give providers and providers time to manage prescription changes, a mechanism for COO to coordinate care transitions and a process for pharmacy claims and drug utilization for care coordination. Examples: [Minnesota 310000](#) and [Minnesota 310000](#).

Medicaid prescription benefit models

Multiple PBMs
Currently, Oregon's Medicaid program uses a multiple PBM model. All 16 COOs have the choice to contract with the Oregon Prescription Drug Program to administer pharmacy benefits, or the COOs can choose to contract with their own PBM. If a PBM model, COOs are their PBM from regulatory perspective received from the OHS (Oregon Health Authority). PBMs are typically responsible for pricing and processing pharmacy claims, developing or supporting the COO's formulary, negotiating with network pharmacies for lower price guarantees, and contracting with drug manufacturers for drug rebates.

Case for COOs to coordinate care across pharmacy and medical benefits.
Outcomes processing and payment of pharmacy claims.
Limited monitoring and knowledge of PBM activities by OHS.
Drug rebates, which can lead to lower costs, are not maintained.
Health equity concerns for members who do not have coordinated access.
Does not leverage purchasing power and economies of scale.

Benefit erosion
A PBM contract includes an online, confidential bidding process that can be used to select a PBM to manage prescription drug benefits. As a result, states that start with an opening price a PBM submit lower competitive bid drug savings rounds. States where savings from PBMs to offer the same contract terms but at a lower price leads to primary medical bidding. Because auctions have been known to generate significant savings to state government programs. Some states have reverse auctions to select PBMs for public employee health plans and established the date will have 32 below in drug bidding between 2017 and 2022. While reverse auctions can lower costs for states, but costs should not be the only factor to consider. There is a risk PBMs might start to stop going to the pharmacy level, which could result in low or no after pharmacy reimbursement and ultimately erode pharmacy access issues. Examples: [Oregon 310000](#) and [MFC 310000](#).

Potential cost savings.
Leverage the market competition.
Ability to drive contract requirements.
Low flexible and additional costs may be incurred through direct.
Less flexible and additional costs may be incurred through direct.
Provider uncertainty between contract terms.

Estimated \$4.4 billion in actual savings during the first year of the transition to PFM. While there is potential for cost savings, some states, like Florida, have determined a move to the model would be the most costly. They may also be negative fiscal impacts to MCOs pharmacies. Examples: [Florida 310000](#) and [Florida 310000](#).

Potential decreased utilization costs.
Potential revenue in federal drug rebates, which could be lower costs.
Rebate volume consistency.
Increased transparency states give greater control of plan details and would decrease monitoring efforts.
Stateline consistency pharmacy benefits administration.
Uniform formulary and coverage criteria.
Leverage economies of scale.

Single PBM
A single PBM model has been used in other states to contract with one PBM for Medicaid managed care or public employee health plans. For many health plans, Medicaid is not the only line of business, and may incur private business as well as health plans typically contract with one PBM for all lines of business, and a move to a single PBM model may require plans to have contracts with multiple PBMs, which could reduce some operational efficiencies. There is also a possibility some plans could contract from Medicaid in this model. Oregon could have some flexibility to maintain MCO pharmacy programs, depending on the program structure, whereas an PFM would not offer this level of flexibility. Examples: [Oregon 310000](#) and [MFC 310000](#).

Potential decreased utilization costs.
Increased transparency allows the state to set contract parameters and would decrease monitoring efforts.
Flexibility in pharmacy provider reimbursement.
Uniform formulary and coverage criteria.
Leverage economies of scale.
Potential to preserve MCO pharmacy revenues, depending on structure.

How does Oregon's Prescription Drug Program compare to other states?
See [Oregon 310000](#) for a comparison of Oregon's PBM model against other states' models.
See [Oregon 310000](#) for a comparison of Oregon's PBM model against other states' models.

When considering new legislation or adoption of new models, it is important to consider both quantitative and qualitative impacts to enrollees, the program, and key stakeholders like local pharmacies. We suggest you reach out to OHS with a drug utilization to discuss the impacts to the program's pharmacy. We have your best interests in mind.

We appreciate OHS time and collaboration during our ongoing audit of PBM. We plan on issuing our audit report next year, which will provide additional details around these leading practices as well as risk areas and report back beyond information if you have any questions please contact Audit Manager on 503-239-7934.

Sincerely,
Kim Monnett,
Director, Health Division
Oregon Secretary of State
CC: Patrick Allen, Director, Oregon Health Authority
CC: Representative Nancy Nathanson, Representative-90th District, Senator Elizabeth Steiner
CC: Chair of Health Services and Health Care Committee on Health Care, Joint Committee on Legislative Affairs
CC: Greg Jagers, Governor's Office

February 6, 2023

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February 6, 2023
House Committee on Professional Health and Health Care
Oregon Legislature
9500 NE Oregon St
Salem, OR 97331

Dear Chair Nease and Vice Chair Goodwin and Nelson:
We are providing information about leading practices related to Pharmacy Benefit Manager (PBM) transparency reporting requirements. We are providing this information now because the Oregon Legislature is considering legislation on this topic, and our audit of Medicaid PBM will include a report regarding these issues. Such practices in accordance with Government Auditing Standards.

To be of maximum use, providing relevant information is done to respond to officials of the audited entity, legislative officials, and other parties legitimate needs to the "audit" goal. Doing this work, the auditor may provide information of significant interest to appropriate entities and oversight officials. Such information can be used by legislative officials to make decisions, investigate allegations and allow them to take corrective action before the fact if any is warranted.

Increased transparency
Reporting requirements
Pharmacies across the country are taking a multifaceted approach in tracking drug prescription drug costs. One area that has received increased attention is the need for more robust PBM data to health care PBM play a key role in the complex pharmacy process and can provide a wide array of services, such as processing claims, performing drug utilization review, creating formularies, and negotiating contracts between health plans, manufacturers, and pharmacies. Over time, their roles and responsibilities have changed from mostly operations applications to being significantly more on many aspects of the prescription drug system.

A lack of transparency in PBM processes has led many states to implement laws requiring PBMs to disclose certain pricing and cost information, such as state or rebate or payments and fees collected from drug manufacturers and pharmacies. PBM reporting requirements have been established in 16 states, as shown in Figure 1.

Figure 1. Other states, but not Oregon, have passed laws requiring PBMs to report information.



Increased transparency

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To evaluate why it is important to capture pricing information from PBMs, we have included a table highlighting how pricing can vary dramatically between PBMs and the pharmacies that dispense the drugs. For Tylenol, a medication used for the treatment of pain, 8 percent, our audit work has identified that retail payment rates resulted in estimated pharmacy fees of \$18.82 per prescription compared to estimated pharmacy gross of \$32.00 per prescription dispensed.

Figure 2. Pharmacy reimbursement rates vary by contracted PBM in Medicaid.

Drug	NC	MD	PA	OR	WA	WV	WY
Pharmacy 1	Tranety	214388	402-21	PHM0	2	\$484.31	\$818.11
Pharmacy 2	Tranety	214388	402-21	PHM0	2	\$484.31	\$134.10
Pharmacy 3	Tranety	214388	402-21	PHM0	2	\$484.31	\$134.10
Pharmacy 4	Tranety	214388	402-21	PHM0	2	\$484.31	\$134.10
Pharmacy 5	Tranety	214388	402-21	PHM0	2	\$484.31	\$134.10

Our audit work is focused on PBMs within the Medicaid program and not those regulated by the Department of Consumer and Business Services (DCBS). It is important to note current state law (ORS 414.012) COOs are not considered Medicaid PBMs under that definition and are therefore not subject to most regulatory requirements. As a result, Medicaid PBMs are not regulated by DCBS, and statutory changes are required if the legislative intent is to capture pricing information from all PBMs operating in the state. Medicaid services are in three people in Oregon and the current limited statutory definition provides an incomplete picture of PBM work being in the state.

When considering new legislation, it is important to consider both quantitative and qualitative impacts to enrollees, the program, and key stakeholders. We suggest reaching out to DCBS and OHS and other stakeholders who are in the legislature to discuss the impacts to the program's pharmacy. We hope you find value in this communication and would be happy to answer any questions you have.

We are in our audit report next year, which will provide additional details around pricing practices as well as risk areas and report back beyond information if you have any questions, please contact Audit Manager on 503-239-7934.

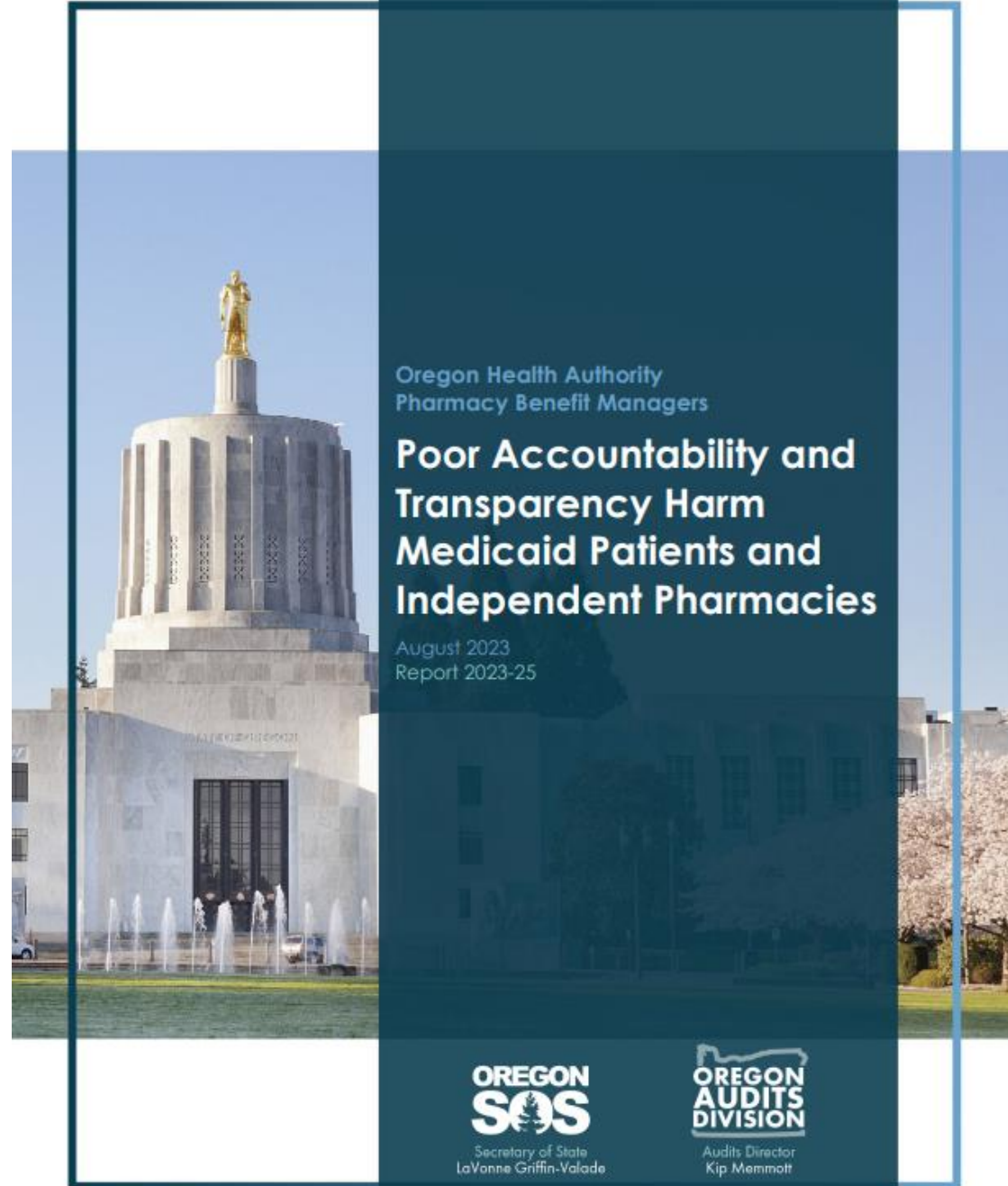
Sincerely,
Kim Monnett,
Director, Health Division
Oregon Secretary of State
CC: James Schwab, Director, Oregon Health Authority
CC: Representative Nancy Nathanson, Representative-90th District, Senator Elizabeth Steiner
CC: Chair of the Senate Committee on Health Care, Joint Committee on Legislative Affairs
CC: Andrea Cooper, Governor's Office

Key Findings

The current structure is too complex

Practices adopted by other states would add value

OHA can improve PBM contract monitoring



Origin and evolution of PBMs

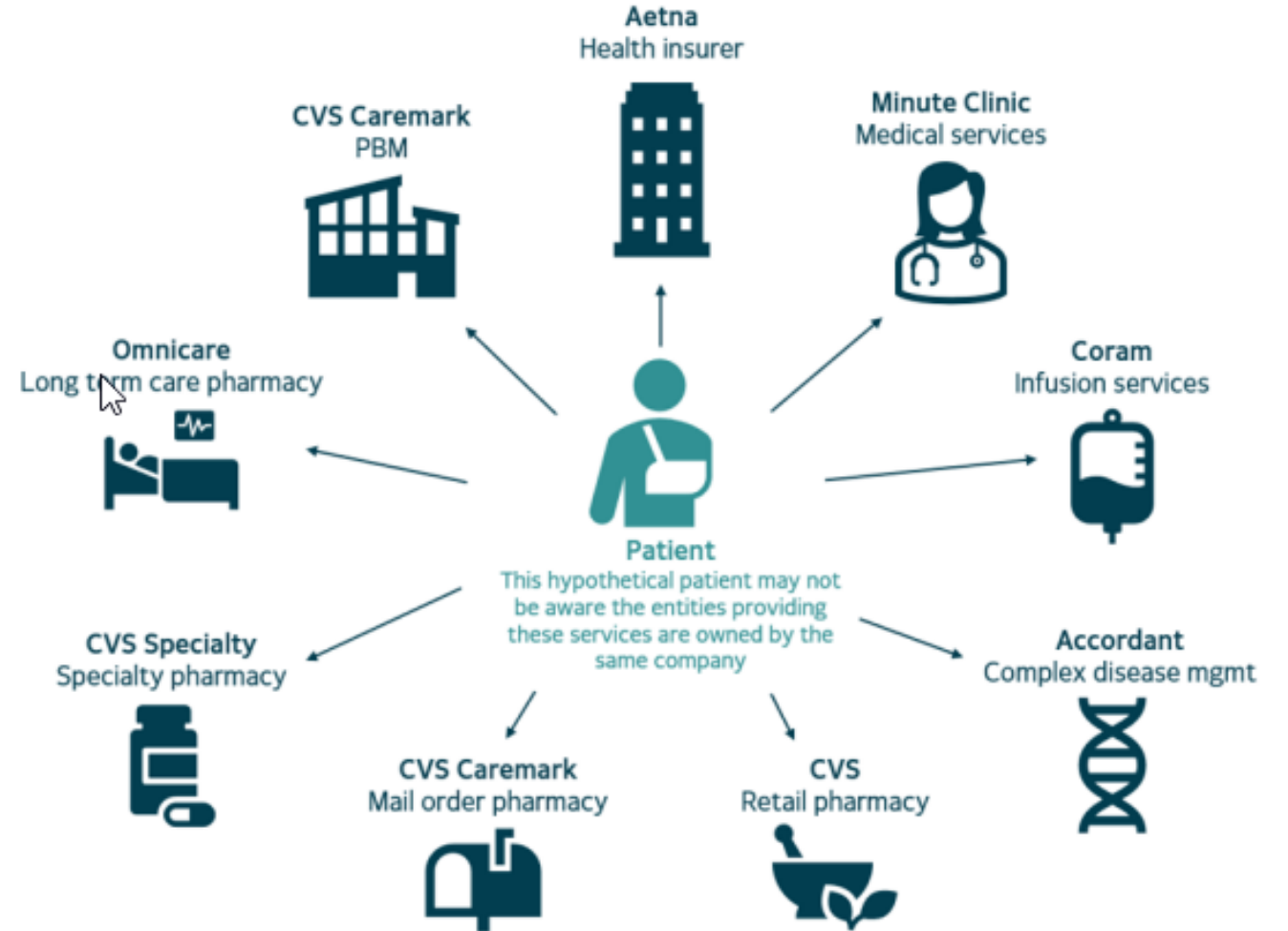
First PBM in 1968

Then: Claims processing

Now: Vertically integrated component of the health care sector

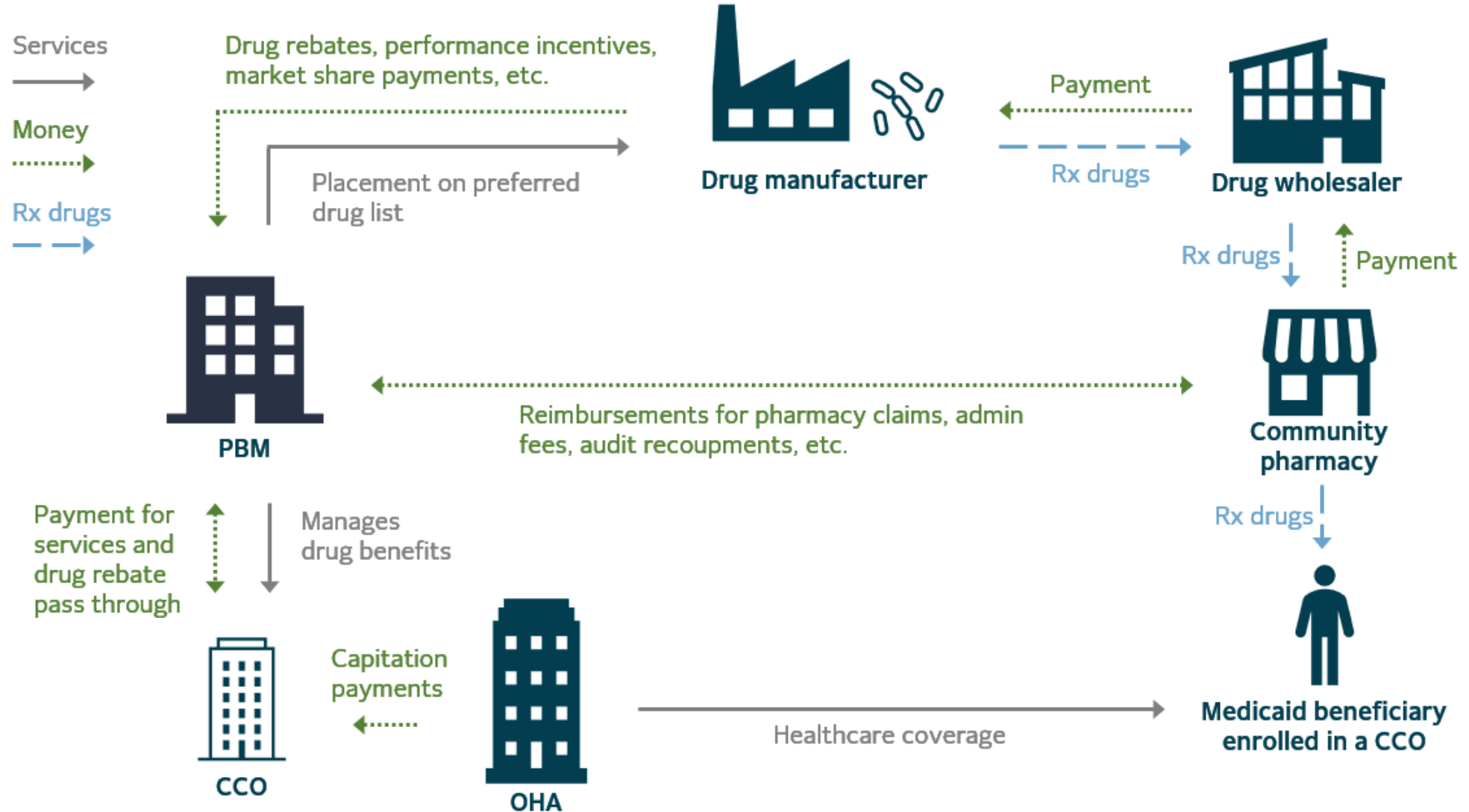
- 3 companies control 80% of market

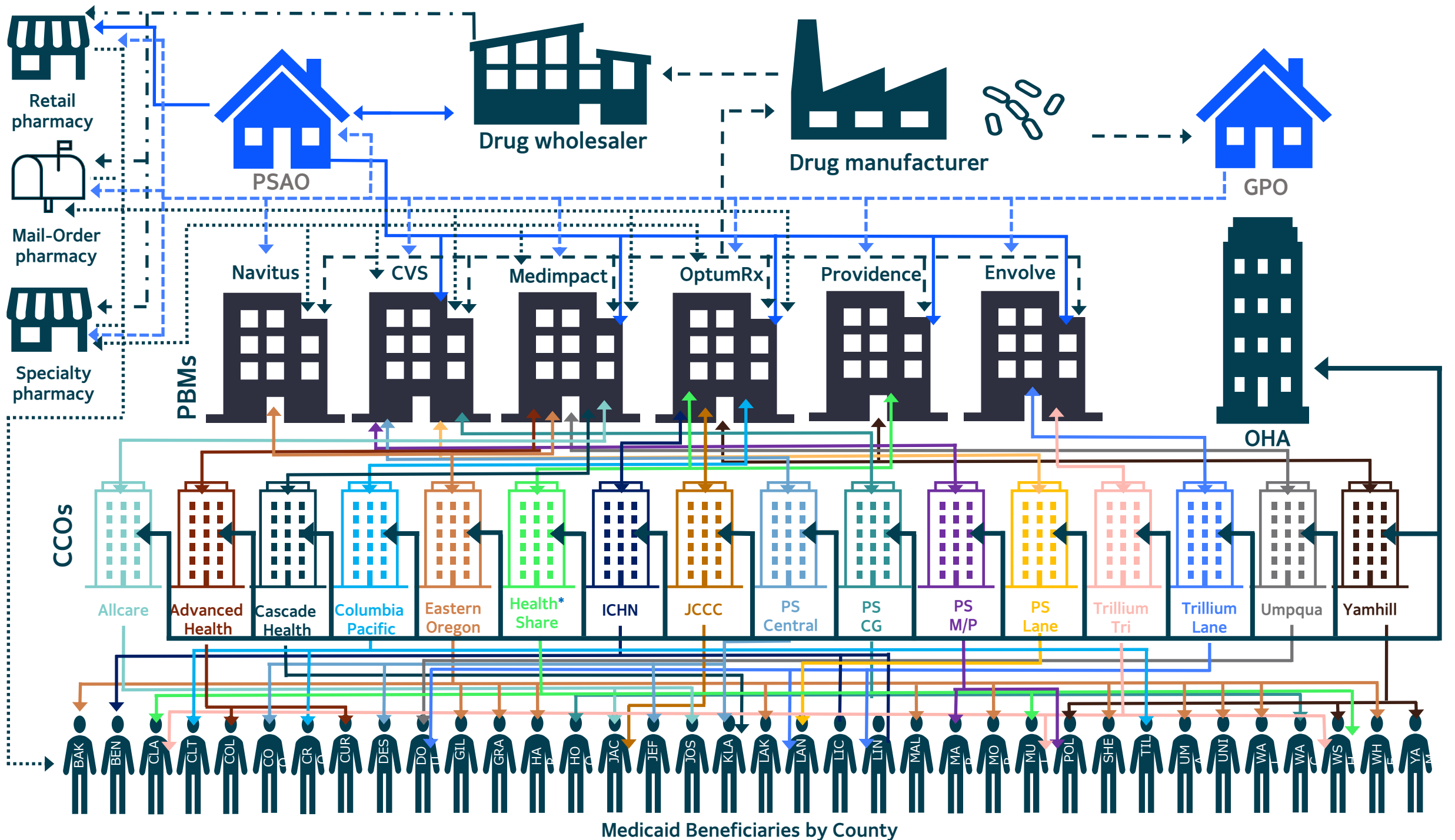
Figure 2: A hypothetical example of a patient who receives care from vertically integrated entities



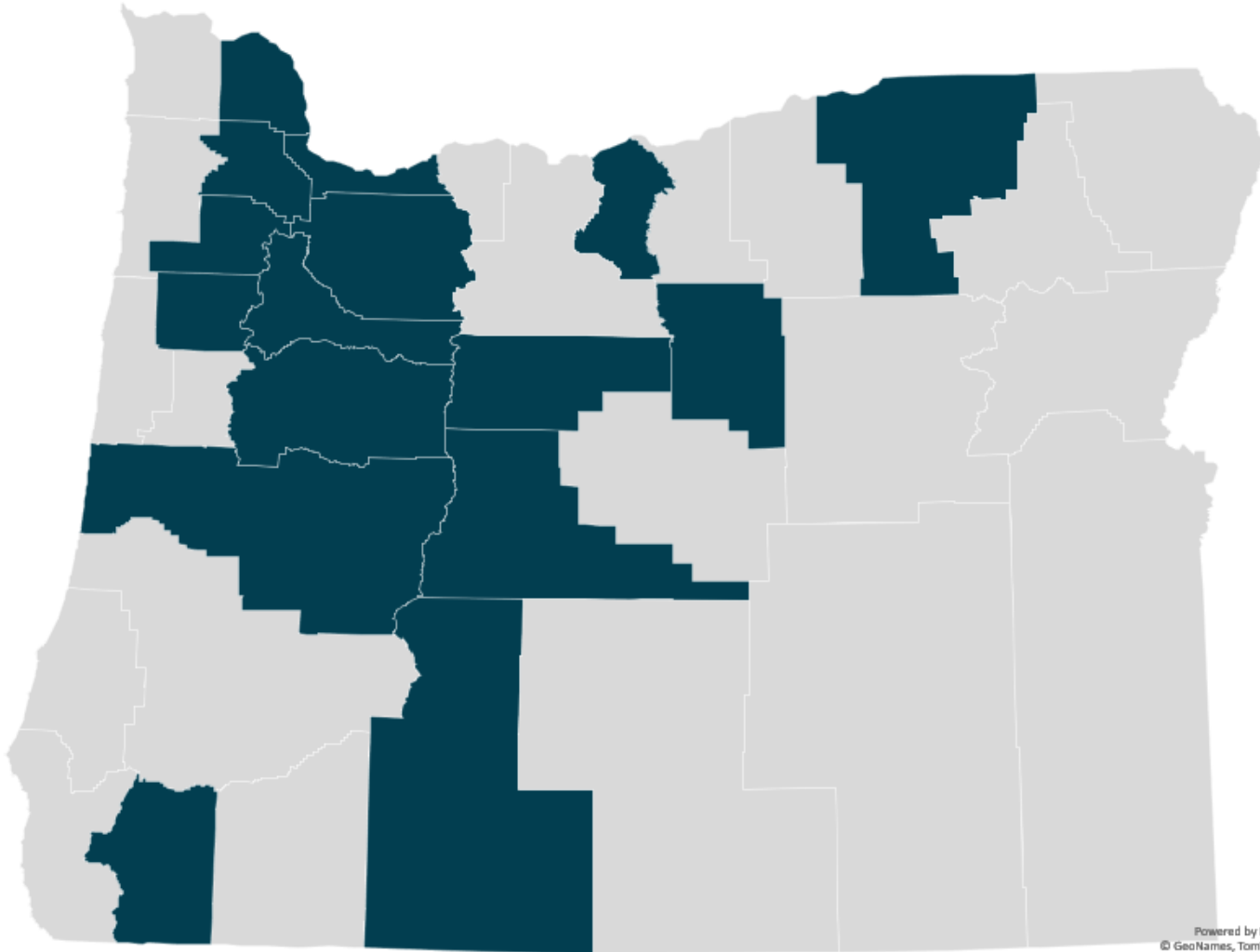
Source: Auditor created based on CVS and subsidiary information

Simplified Model of Oregon's Medicaid PBM System





Oregon needs more community pharmacies



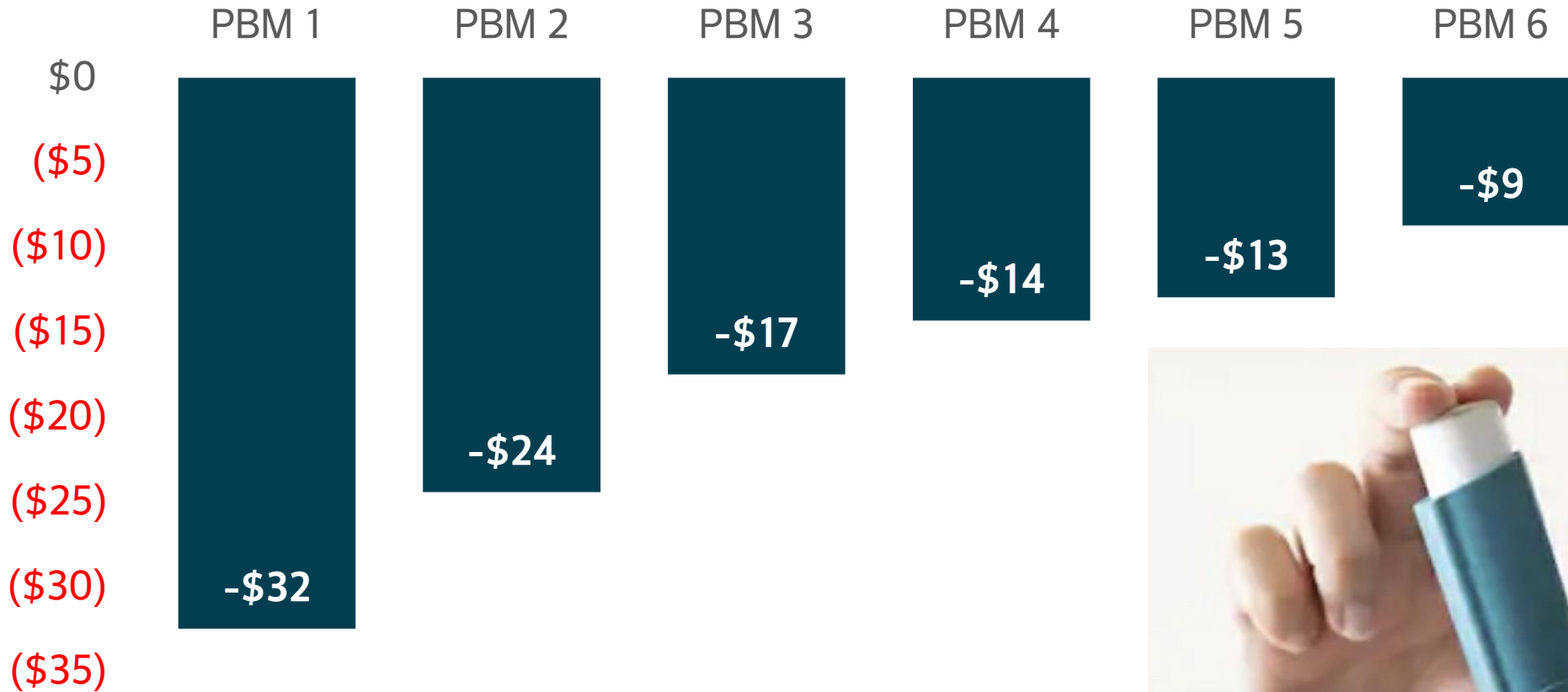
Counties below the national average for pharmacies per 10,000 people

- Clackamas
- Columbia
- Deschutes
- Jefferson
- Josephine
- Klamath
- Lane
- Linn
- Marion
- Multnomah
- Polk
- Sherman
- Umatilla
- Washington
- Wheeler
- Yamhill



Murray's Pharmacy in Heppner Oregon serves over 3,000 square miles

Pharmacies lose money filling lifesaving prescriptions



Pharmacies lost \$1.3 million filling 71,000 Albuterol Sulfate prescriptions in 2021



Reimbursement rates vary considerably

Figure 14: Pharmacy reimbursements vary widely between selected prescription drugs in 2021

Drug	Number of claims tested	Dollar amount tested	Est. total pharmacy profit/loss	Est. average pharmacy profit/loss per claim
Acetaminophen (Tylenol)	12,178	\$28,349	\$4,269	\$0.35
Albuterol Sulfate	70,955	\$2,766,642	-\$1,315,643	-\$18.54
Amoxicillin	13,608	\$51,462	\$35,067	\$2.58
Basaglar	45,767	\$16,790,230	\$219,619	\$4.80
Biktarvy	6,195	\$20,369,308	\$192,792	\$31.12
Budesonide and Formoterol Fumarate Dihydrate	14,924	\$4,079,910	\$865,952	\$58.02
Buprenorphine and Naloxone	26,101	\$3,766,875	\$1,238,829	\$47.46
Eliquis	17,743	\$8,457,352	\$48,779	\$2.75
Flovent	12,868	\$3,357,669	\$56,127	\$4.36
Humira	3,947	\$26,178,519	\$25,836	\$6.55
Metformin	26,184	\$124,781	\$62,680	\$2.39
Omeprazole	47,812	\$176,185	\$117,167	\$2.45
Trulicity	18,473	\$15,267,881	\$716,139	\$38.77
Total	316,755	\$101,415,163	\$2,267,613	

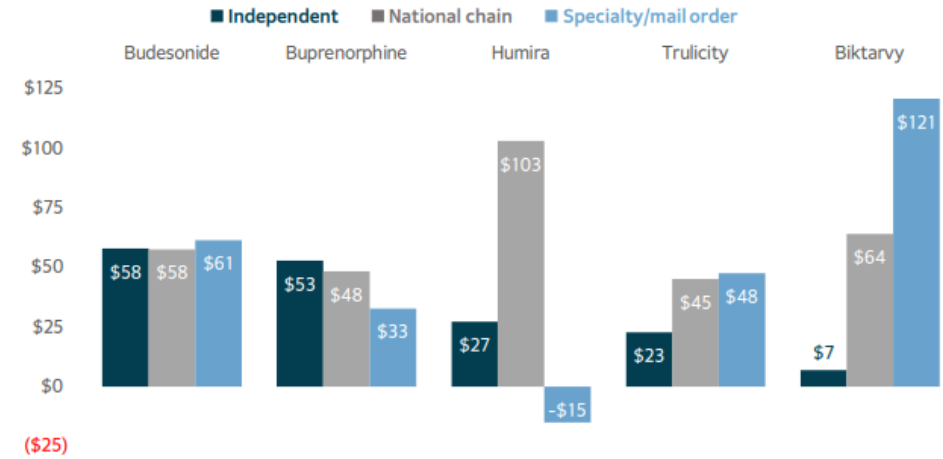
Source: Auditor analysis of OHA and PBM 2021 claims data and Oregon average acquisition cost data

Figure 3: Pharmacy reimbursement rates are inconsistent between PBMs in Medicaid

	Drug	NDC	Month	PBM	Number of units	Average Oregon acquisition cost	Estimated pharmacy profit/loss
Prescription 1	Trulicity	2143380	Apr-21	PBM1	2	\$404.31	(\$58.82)
Prescription 2	Trulicity	2143380	Apr-21	PBM2	2	\$404.31	(\$16.58)
Prescription 3	Trulicity	2143380	Apr-21	PBM3	2	\$404.31	\$9.57
Prescription 4	Trulicity	2143380	Apr-21	PBM4	2	\$404.31	\$19.50
Prescription 5	Trulicity	2143380	Apr-21	PBM5	2	\$404.31	\$53.29

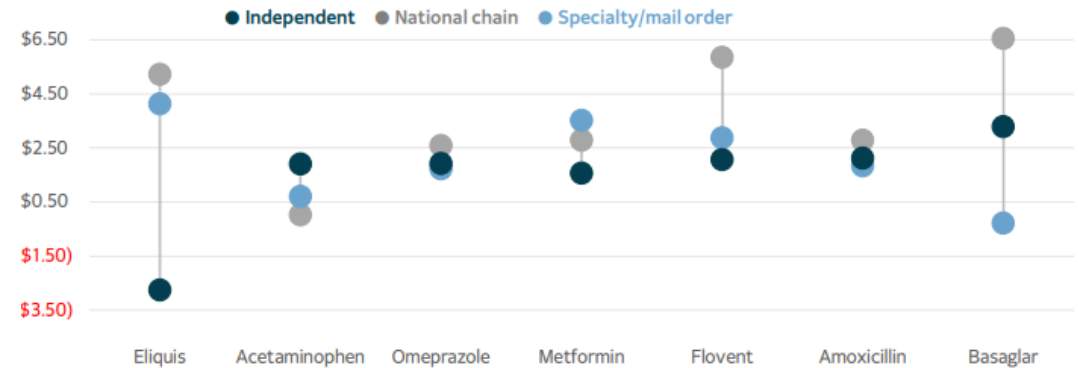
Source: Preliminary auditor analysis of OHA and PBM Medicaid data

Figure 16: Estimated pharmacy profits for some brand name drugs differ significantly depending on pharmacy type



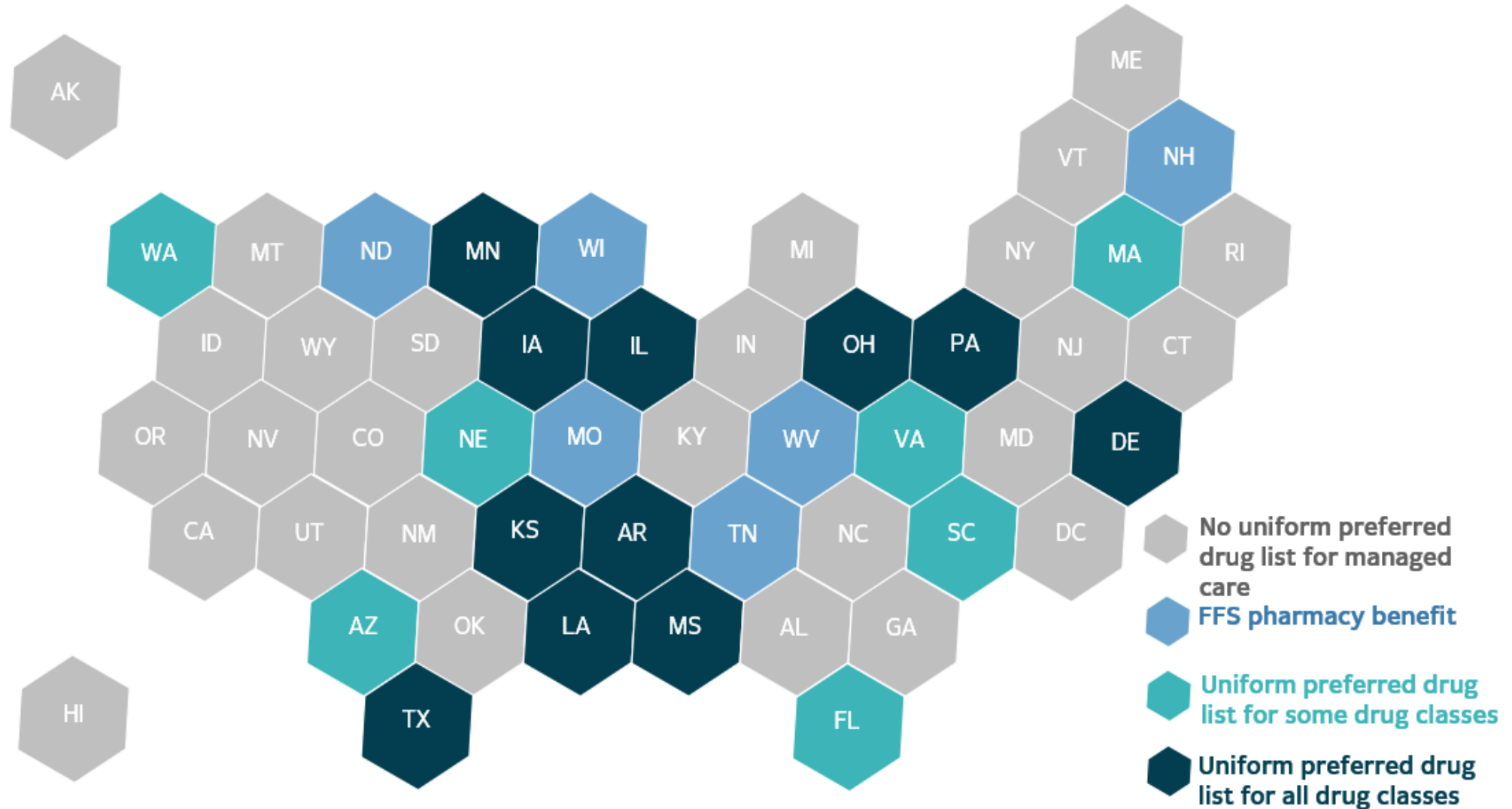
Source: Auditor analysis of OHA and PBM 2021 claims data and Oregon Average Acquisition Cost data

Figure 17: National and specialty/mail order pharmacies were reimbursed more than independent pharmacies for most drugs tested



Source: Auditor analysis of OHA and PBM 2021 claims data and National and Oregon Average Acquisition Cost data

Patient protections – uniform preferred drug list



Transparency – PBM reporting requirements

New due to
SB192 (2023)



	<u>OR</u>	<u>CT</u>	<u>GA</u>	<u>IN</u>	<u>IA</u>	<u>LA</u>	<u>MI</u>	<u>MN</u>	<u>MT</u>	<u>NV</u>	<u>NH</u>	<u>NY</u>	<u>TX</u>	<u>UT</u>	<u>VT</u>	<u>VA</u>	<u>WI</u>
Drug rebates from drug manufacturers or other sources	●	●	●	●	●	●	●	●	●	●	●	●	●	●		●	●
Drug rebates passed though and/or retained	●	●		●		●	●	●	●	●			●			●	●
Admin fees from health plans					●		●	●	●	●		●		●			●
Admin fees from pharmacies					●		●	●	●	●		●					
Admin fees from drug manufacturers	●			●	●		●	●	●	●		●	●	●			●
All admin fees retained	●				●		●	●	●				●				
Spread pricing retained			●				●	●	●						●		
Data collection			●				●	●	●								
Public reporting			●		●	●					●		●				●



Recommendations

OHA

- Improve contracts and expand monitoring of PBMs

Legislature

- Select different PBM model
- Require uniform preferred drug list
- Create fair pharmacy reimbursement policy
- Include Medicaid PBMs in ORS 735.530 (DCBS statutes)
- Require PBMs to act as fiduciaries
- Increase PBM reporting requirements
- Study centralized drug purchasing program

Questions?

Key Recommendation Simplify the Medicaid PBM system

Kip Memmott

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